AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Consultation Draft

Severe (third and fourth degree) Perineal Tears

Clinical Care Standard

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The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information in the clinical care standard. Consumers should use the clinical care standard as a guide to inform discussions with their healthcare professionals about the applicability of the clinical care standard to their individual condition.

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Contents

Severe (third and fourth degree) Perineal Tears Clinical Care Standard quality statements at a glance

1 Information, shared decision making and informed consent

Beginning in the antenatal period, a woman receives individualised information about the potential for severe perineal tears and is supported to make decisions and provide informed consent for the care she receives.

2 Reducing risk during pregnancy, labour and birth

A woman receives care during pregnancy, labour and birth to reduce her risk of severe perineal tears. Care is aligned with evidence-based guidelines and reflects the woman's care preferences.

3 Instrumental vaginal birth

When intervention is necessary for the safe birth of the baby, the choice of instrument is based on clinical need and consideration of the benefits and risks for each option, including the risk of a severe perineal tear.

4 Identifying third and fourth degree perineal tears

After a vaginal birth, and with her consent, a woman is examined by an appropriately trained clinician to exclude the possibility of a third or fourth degree perineal tear. Tears are classified using the Royal College of Obstetricians and Gynaecologists classification and are documented in the healthcare record.

5 Repairing third and fourth degree perineal tears

When a third or fourth degree perineal tear occurs, it is promptly repaired by an appropriately trained and experienced clinician in a suitable environment.

6 Postoperative care

After repair of a severe perineal tear, a woman receives postoperative care that includes debriefing, physiotherapy and psychosocial support before discharge.

7 Follow-up care

A woman with a severe perineal tear receives individualised follow-up care and appropriate referral to optimise her ongoing physical, emotional, psychological and sexual health.

Indicators for local monitoring

Instrumental delivery rate for first birth

1) Proportion of women who had an instrumental vaginal birth for their first birth

Numerator - number of women who had an instrumental vaginal birth for their first birth

Denominator – number of women who gave birth vaginally for their first birth

Vacuum-assisted and forceps-assisted delivery rate for first birth*

2) Proportion of women who had an instrumental vaginal birth using vacuum for their first birth

Numerator – number of women who had an instrumental vaginal birth using vacuum for their first birth

Denominator – number of women who gave birth vaginally for their first birth

3) Proportion of women who had an instrumental vaginal birth using forceps for their first birth

Numerator – number of woman who had an instrumental vaginal birth using forceps for their first birth

Denominator – number of women who gave birth vaginally for their first birth

***Computation notes**

Women who had an instrumental vaginal birth using both vacuum and forceps should be capture in indicator 3 only (instrumental vaginal birth using forceps)

Instrumental delivery with episiotomy for first birth

4) Proportion of women who had a vacuum-assisted birth with episiotomy for their first birth

Numerator – number of women who had an instrumental vaginal birth using vacuum and had an episiotomy performed

Denominator – number of women who had an instrumental vaginal birth using vacuum for their first birth

5) Proportion of women who had a forceps-assisted birth with episiotomy for their first birth

Numerator – number of women who had an instrumental vaginal birth with forceps and had an episiotomy performed

Denominator – number of women who had an instrumental vaginal birth with forceps for their first birth

Dual instrumental delivery rate for first birth

6) Proportion of women who had an instrumental vaginal birth using both vacuum and forceps for their first birth

Numerator – number of women who had an instrumental vaginal birth with forceps and vacuum

Denominator – number of women who had an instrumental vaginal birth for their first birth

Hospital-acquired complications – third and fourth degree perineal laceration during delivery

7) Proportion of women who gave birth and acquired a third degree perineal laceration

Numerator – number of women who gave birth and acquired a third degree perineal laceration

Denominator – number of women who gave birth vaginally

8) Proportion of women who gave birth and acquired a fourth degree perineal laceration

Numerator – number of women who gave birth and acquired a fourth degree perineal laceration

Denominator – number of women who gave birth vaginally

About clinical care standards

Clinical care standards aim to support the delivery of appropriate evidence-based clinical care, and promote shared decision making between patients, carers and clinicians.

A clinical care standard contains a small number of quality statements that describe the clinical care a patient should be offered for a specific clinical condition or when undergoing a specific procedure. It is based on the best-available evidence at the time of development. Some of the quality statements are linked to indicators that can be used by health service organisations to monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from, and is not intended to be, a clinical practice guideline. Rather than describing all the components of care recommended for managing a clinical condition or performing a certain procedure, a clinical care standard addresses areas of the patient pathway where the need for quality improvement is greatest.

Clinicians are advised to use clinical judgement and consider an individual patient's circumstances, in consultation with the patient, or their carer or guardian, when applying the information in a clinical care standard. Health service organisations are responsible for ensuring that local policies, processes and protocols to guide clinical practice are in place, so that clinicians can apply the information described in the clinical care standard, and so that clinicians and health service organisations can monitor the delivery of appropriate care.

Clinical care standards aim to support key groups of people in the healthcare system by:

- Educating the public about the care that the healthcare system should offer, and helping people to make informed treatment decisions in partnership with their clinicians
- Providing clear information to clinicians to help them make decisions about appropriate care
- Outlining the systems required by health service organisations so that they are better able to review their performance and make improvements in the care that they provide.

The Australian Commission on Safety and Quality in Health Care (the Commission) developed the Severe Perineal Tears Clinical Care Standard in collaboration with consumers, clinicians, researchers and health service organisations. The clinical care standard complements existing efforts, including state- and territory-based initiatives that aim to reduce complications associated with severe perineal tears.

For more information about this clinical care standard visit https://www.safetyandquality.gov.au/our-work/clinical-care-standards/

About the Australian Commission on Safety and Quality in Health Care

The Commission is an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care based on the best-available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

Severe (third and fourth degree) perineal tears

A perineal tear is a tear of the skin and other tissues between the vagina and anus (the perineum). Perineal tears are an adverse outcome of vaginal births, and while minor (first and second degree tears) are more common, most vaginal births do not result in any major damage to the perineum or anus.[1] However, about 3% of women who have a vaginal birth will experience a severe (third or fourth degree) perineal tear[2,3], which may affect their physical, psychological and sexual wellbeing.

Perineal tears that are skin deep (first degree tears) or involve the perineal muscle (second degree tears)[4] may need stitches, but women tend to recover from this type of injury within the first few weeks or months after birth.[5]

Severe perineal tears are deeper than first and second degree tears and involve the:

- Muscles and sphincter that control the anus (third degree tears), or
- Lining of the anus or rectum (fourth degree tears).[4]

Severe perineal tears need surgical repair and may be associated with increased short- and long-term complications for women including:

- Perineal pain
- Faecal and flatus incontinence
- Painful sexual intercourse
- Reduced quality of life
- Depression.[5, 6]

There are also considerable social and emotional implications for women, which may affect their psychological wellbeing.[5, 7]

This standard, focuses on third and fourth degree perineal tears, which are collectively known as severe perineal tears.

Problems associated with severe perineal tears

In 2013, 3% of all Australian women who gave birth vaginally were reported as having a severe perineal tear. This rate is above the reported average for similar Organisation for Economic Cooperation and Development countries. There is also significant variation in rates and reporting across the country. In 2013–14, the number of Australian women who had a severe perineal tear ranged from 6 to 71 per 1,000 vaginal births across 301 local areas. The area with the highest rate was 11.8 times higher than the area with the lowest rate. The number of women who had a severe perineal tear also varied across states and territories.[2]

The reasons for this variation could be related to practices such as:

- Changes in the proportion of instrumental vaginal births
- Changes in the proportion of instrument used (forceps compared with vacuum)
- Changes in other practices during the second stage of labour – for example, maternal position, speed and duration of labour, and methods used to protect or support the perineum.[2]
- Changes in the rate and type of episiotomy, based on the angle of incision
- Better identification and reporting of severe perineal tears

The Australian Institute of Health and Welfare identified a number of risk factors for severe perineal tears including:

- Instrumental vaginal birth, especially with forceps
- Maternal country of birth – women from south Asian ethnic backgrounds have higher rates of severe perineal tears

- Hospital sector – women in public hospitals have a higher rate of severe perineal tears, which may be due to differences in reporting or the cultural diversity of the patient population.[5]

Severe perineal tears are more likely to occur in the following circumstances:

- A woman having her first vaginal birth
- Being of south Asian ethnicity
- Having a prolonged second stage of labour
- Having an instrumental vaginal birth – that is, with forceps or vacuum
- When the baby's shoulder is lodged behind the woman's pelvic bone (shoulder dystocia)
- Giving birth to a large baby
- Having a previous severe perineal tear.[4]

Improving perineal outcomes

It is not always possible to prevent a severe perineal tear. However, using evidence-based practices may reduce a woman's risk during labour and birth. Health service organisations need to ensure that clinicians are appropriately trained and skilled to provide evidence-based care to reduce the woman's risk, and to accurately identify, report and repair severe perineal tears when they do happen.

Health service organisations should use a quality improvement approach to monitor variation in practice against expected health outcomes. Organisations should then use this information to improve safety and quality, and deliver high-quality care.

Box 1. WHA CEC Perineal Protection Bundle[8]

Women's Healthcare Australasia (WHA) implemented a quality improvement initiative that aims to improve outcomes for women by reducing avoidable third and fourth degree perineal tears[42.] The WHA National Collaborative was hosted by WHA in partnership with the NSW Clinical Excellence Commission and supported by Safer Care Victoria and the Clinical Excellence Division of Queensland Health.

The elements of care, which are further described in the WHA CEC Perineal Protection Bundle include:

1. Apply a warm perineal compress during the second stage of labour at the commencement of perineal stretching.
2. With a spontaneous vaginal delivery, using gentle verbal guidance, to encourage a slow controlled birth of the fetal head and shoulders.
3. When episiotomy is indicated, it should be performed: at crowning of the fetal head, using a medio-lateral incision, at a minimum 60 degree angle from the fourchette. Note: Due to the increased risk of third or fourth degree perineal tears when a woman having her first vaginal birth requires the assistance of forceps or vacuum, an episiotomy should be offered.
4. For all woman, genito-anal examination following birth needs to be offered, and where consent is given: be performed by an experience clinician, include a PR examination for all women, including those with an intact perineum.
5. All perineal trauma should be graded according to the RCOG guideline, reviewed respectfully by a second experienced clinician to confirm diagnosis & grading.

WHA recommends implementing all five components of the bundle for each woman.

About this clinical care standard

Why this is needed

Accurate detection and appropriate repair of severe perineal tears is important to minimise the risk of infection, blood loss, pain and incontinence.[6, 9] If severe perineal tears are not recognised, classified correctly and repaired promptly, they can have serious long-term consequences.

Surgical repair is effective in eliminating symptoms for 60–80% of affected women, but some women may be permanently affected despite appropriate treatment.[6, 10] Women with a severe perineal tear should receive care to optimise their recovery in the postoperative period and appropriate follow-up care to optimise their physical and psychosocial wellbeing.

Goal

The goal of this standard is to reduce unwarranted variation and improve the care provided to women to reduce their risk of severe perineal tears. It also aims to ensure that women who experience a severe perineal tear receive holistic care to optimise their physical and psychological recovery.

Scope

This clinical care standard applies to all pregnant women who are planning a vaginal birth and women who experience a severe perineal tear. It focuses on:

- Providing information to women based on their relevant risk factors and clinical need
- Providing evidence-based care to reduce their risk
- Classifying and reporting severe perineal tears using a standardised system
- Repairing severe perineal tears promptly, in a suitable environment
- Providing postoperative care that includes early access to debriefing, physiotherapy and psychosocial support
- Ensuring women receive appropriate follow-up care to optimise their physical, psychological and sexual wellbeing.

Pathway of care

This standard applies to care provided in the antenatal and postnatal period. It is relevant in all settings of care where maternity services are provided, including:

- Public and private hospitals
- Clinics
- Birthing centres
- Community and home-based care.

This standard applies to all maternity clinicians, including:

- General practitioners
- Midwives and women's health nurses
- Aboriginal and Torres Strait Islander health providers
- Obstetricians and gynaecologists
- Colorectal surgeons
- Physiotherapists
- Psychologists.

What is not covered

This standard does not cover:

- The surgical procedure to repair a severe perineal tear or any complications that arise from this surgery
- Treatment of complications associated with severe perineal tears that were not recognised or treated in the perinatal period
- Other obstetric injuries or complications such as rectal buttonhole injuries, or vaginal, cervical or urethral lacerations.

Evidence that underpins this clinical care standard

The key evidence-based guidelines that underpin the Severe Perineal Tears Clinical Care Standard include:

- American College of Obstetricians and Gynecologists, *Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery*[11]
- Society of Obstetricians and Gynecologists of Canada, *No. 148-Guidelines for Operative Vaginal Birth*[12]
- World Health Organisation, *World Health Organisation Recommendation on Techniques for Preventing Perineal Trauma During Labour*[13]
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Instrumental vaginal delivery*[14]
- Royal College of Obstetricians and Gynaecologists, *Management of Third and Fourth degree Perineal Tears*[6]
- Society of Obstetricians and Gynecologists of Canada, *Obstetrical Anal Sphincter Injuries (OASI): Prevention, Recognition and Repair*[15]
- National Institute for Health and Care Excellence, *Intrapartum Care for Healthy Women and Babies. Clinical Guideline 190*[9]
- Royal College of Obstetricians and Gynaecologists, *Operative Vaginal Delivery.*[16]

Supporting documents

A suite of supporting documents for this clinical care standard is available on the Commission's website at https://www.safetyandquality.gov.au/our-work/clinical-care-standards/xxxxxx.

How to use this clinical care standard

This clinical care standard describes the key components of care for reducing a woman's risk of severe perineal tears. It should be used to provide high-quality, evidence-based care, taking into account the context in which care is provided, local variation in care, and the quality improvement priorities of the individual health service organisation.

When implementing the clinical care standard, health services and clinicians should consider integration with the following:

- Indicators for the Severe Perineal Tears Clinical Care Standard – these are listed in Appendix A
- Other quality measures such as patient-reported outcome measures and patient experience measures; see Appendix A
- The National Safety and Quality Health Service (NSQHS) Standards (second edition)[17]; see Appendix B
- *Hospital-Acquired Complications Information Kit* – third and fourth degree perineal laceration during delivery.[18]

General principles of care

Clinicians are advised to use clinical judgement and consider a woman's individual circumstances when applying the information in this clinical care standard.

Health service organisations are responsible for ensuring that local policies, processes and protocols to guide clinical practice are in place. This enables clinicians and health service organisations to apply the information in the clinical care standard and monitor the delivery of appropriate care.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.[17, 19]

Clinical care standards support the key principles of person-centred care, namely:

- Treating patients with dignity and respect
- Encouraging patient participation in decision-making
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand so they can take part in decision-making[20]
- Ensuring patients can provide informed consent.

In the maternity setting, 'woman-centred care' recognises the woman's baby, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. It considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. It respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices. – Nursing and Midwifery Board of Australia[21]

Multidisciplinary care

Women receiving maternity care are likely to need specific types of care provided by various clinicians. In this document, the term 'clinician' refers to all types of health professionals who

provide direct clinical care to women. Multidisciplinary care refers to comprehensive care provided by different clinicians (for example, doctors, midwives, nurses, pharmacists, physiotherapists, psychologists and other allied health professionals) from one or more organisations, who work collectively with the aim of addressing as many of the woman's health and other needs as possible.[22]

Multidisciplinary care can improve health outcomes, and offers more efficient use of health resources. Planning, coordination and regular communication between clinicians are essential components of multidisciplinary care.[22]

Competencies and service capability

Maternity care is provided in a number of different settings, using a range of models of care including:

- Private obstetrician (specialist) care
- Private midwifery care
- General practice obstetrician care
- Public hospital maternity care and high-risk maternity care
- Community and home-based care
- Postnatal clinics specialising in the treatment of severe perineal tears.

This clinical care standard recognises that the suitability of a specific surgical procedure or approach depends on the individual characteristics of the woman receiving care and the scope of clinical practice of the clinician. Safety and quality of care may be at risk if the workforce does not have the appropriate skills or experience.[23] The procedural and surgical skills required to identify, classify and repair severe perineal tears must be considered in the context of the clinical service capacity of the organisation.[24, 25]

Integrated approach to care

An integrated, systems-based approach supported by health service organisations and their networks is central to the delivery of person-centred care as identified in this clinical care standard.

Key elements of this approach include:

- Understanding the capacity and limitations of each component of the healthcare system across metropolitan, regional, rural and remote settings
- Developing clear lines of communication between components of the healthcare system, including primary care, hospital, subacute and community services
- Ensuring appropriate coordination so that people receive prompt access to the best care, regardless of how or where they enter the system.

To achieve these aims, health service organisations implementing this standard may need to:

- Deploy an active implementation plan and feedback mechanisms
- Include agreed protocols and guidelines, decision support tools and other resource materials
- Employ a range of incentives and other measures to influence behaviours, and encourage compliance with policies, protocols, regulations and procedures
- Integrate risk management, governance, and operational processes and procedures, including education, training and orientation.[25]

Quality statement 1 – Information, shared decision making and informed consent

Beginning in the antenatal period, a woman receives individualised information about the potential for severe perineal tears and is supported to make decisions and provide informed consent for the care she receives.

Purpose

To ensure that women receive information in the antenatal period about the potential for severe perineal tears, relevant risk factors and evidence-based care to reduce their risk.

To support woman to make decisions and provide informed consent for the care they receive during pregnancy, labour and birth.

What the quality statement means

For women

During the antenatal period, your clinician will talk to you about your birthing options such as a vaginal birth, an instrument-assisted birth or a caesarean section. They will also discuss the possibility of having a severe perineal tear and what can be done to lower the chance of this happening.

Most women who give birth vaginally do not sustain significant damage to their perineum or anus, but some women sustain a severe perineal tear. It is not always possible to prevent a severe perineal tear. There are care options that can reduce the likelihood of this happening. These options are based on the best-available evidence. You can make an informed choice about the care you receive by talking to your clinician about the potential benefits and harms of these options. The option you choose will be based on your clinical need and personal preferences.

Not all care settings can offer all care options. If this is the case for you, you may be referred to an obstetrician or transferred to a different care setting. This will depend on your level of risk, previous birth history and your decisions about the care you wish to receive.

Your clinician will also discuss the importance of being checked soon after your baby is born to make sure you do not have this type of injury. This discussion will be recorded in your healthcare record.

For clinicians

During the antenatal period, inform women about the potential for severe perineal tears. Provide individualised information about the likelihood of having this type of injury, based on the woman's obstetric history and relevant risk factors. Box 2 summarises the maternal and fetal risk factors, and those that may emerge during labour and birth.

Discuss the evidence-based options to reduce risk during pregnancy, labour and birth, including the likely benefits and risks for each option. Refer the woman to an obstetrician, if required, especially women who are at higher risk, have experienced female genital mutilation or had a previous severe perineal tear. Discuss the importance having an examination soon after birth, to exclude this type of injury.

Provide information in a way that is easy for the woman to understand. Present information in a format that meets her needs – for example, use large print or audio if necessary. Consider the woman's cultural background and provide information that is culturally sensitive

or translated into different languages. Offer other support services, such as interpreter services, or support from an Aboriginal health worker, if needed.

Consider the woman's health literacy and her ability to appraise information and make effective decisions about her care. Give women the opportunity to discuss this information with you and ensure they can take part in decision-making and care-planning activities.[9, 13, 26]

Document the outcome of this discussion in the woman's healthcare record or birth plan, including any preferences for, or objections to, a particular care option. Advise women that they may need to reconsider these options if circumstances change.

Box 2: Clinical risk factors associated with severe perineal tears[5, 6, 11, 12]

Maternal and fetal risk factors

- Primiparity
- Women of south Asian ethnicity
- Vaginal birth after caesarean section
- Shortened perineal length, posterior fourchette to mid-anus <2.5 cm
- Previous severe perineal tear
- Baby's birth weight >4 kg
- Persistent occipito-posterior position
- Shoulder dystocia
- Large head circumference of baby

Risk factors during labour and birth

- Instrumental vaginal delivery (forceps or vacuum)
- Prolonged second stage of labour
- Epidural analgesia
- Labour induction
- Labour augmentation
- Midline episiotomy
- Birthing position (supine, lithotomy or deep-squatting positions)

For health service organisations

Ensure that policies and procedures are in place regarding information provision, shared decision making and informed consent.[25,17]

Work in partnership with women and clinicians to ensure that written information about severe perineal tears is consistent with current evidence-based guidelines. This information should be easy to use, meet the health literacy and cultural diversity of the local population, and be readily accessible.[27]

Ensure that clinicians are appropriately trained to support women to make informed choices using a shared decision-making framework. Women should have an opportunity to discuss the information provided with their clinician and to provide informed consent for the care they receive.[17]

Ensure that systems are in place to record the key outcomes of the discussion and to enable sufficient clinical communication between clinicians. This is especially important when care is provided by a multidisciplinary team, a shared-care model is being used, or women are referred to another clinician or transferred to a different care setting.[17]

Quality statement 2 – Reducing risk during pregnancy, labour and birth

A woman receives care during pregnancy, labour and birth to reduce her risk of severe perineal tears. Care is aligned with evidence-based guidelines and reflects the woman's care preferences.

Purpose

To ensure that women are appropriately assessed and receive evidence-based care to reduce their risk of a severe perineal tear during pregnancy, labour and birth.

What the quality statement means

For women

It is not always possible to prevent a severe perineal tear, but evidence-based care can be used during pregnancy, labour and birth to reduce the likelihood of this happening.

Throughout pregnancy, it is important to eat a healthy diet and exercise regularly to help maintain a healthy weight for you and your baby. In the later stages of pregnancy, pelvic floor muscle training can reduce the possibility of a severe perineal tear by preparing your perineal muscles for labour and birth.[28] Perineal self-massage after 34 weeks of pregnancy may also help prepare your perineum.[5, 29]

During labour, your clinician will assess you and, with your consent, will provide care to reduce the chances of a severe perineal tear. Evidence suggests that applying warm compresses[30] to the perineum and encouraging you to slow the rate at which the baby emerges can significantly reduce your risk. Changing your birthing position may also help.

Your clinician may also recommend an episiotomy to reduce the likelihood of a severe perineal tear. An episiotomy is when a cut is made in the vaginal opening to make more space to deliver the baby.[4]

If you need help giving birth, you may have an instrumental vaginal birth (where instruments such as forceps or a vacuum are used) or a caesarean section (where the baby is born via a cut through the abdomen and uterus).[4] This may involve a transfer of care to an obstetrician or a different setting such as an operating theatre.

For clinicians

During the antenatal period, advise women about options that may reduce the risk of severe perineal tears during pregnancy, labour and birth.

During pregnancy advise women of importance of eating well and exercising regularly to maintain a healthy maternal and fetal birth weight.[31] Inform women that pelvic floor muscle training can reduce risk by preparing the perineal muscles for labour and birth.[28] Perineal self-massage after 34 weeks of gestation may also help prepare the perineum.[5, 13, 29]

During labour, refer to the woman's care plan and assess her regularly to identify emerging risk factors for a severe perineal tear. With consent, provide evidence-based care to reduce the risk of a severe perineal tear – for example, by:

- Applying warm compresses on perineal distortion (high-grade evidence)[5, 13, 30, 32]
- Slowing the rate at which the baby emerges during the second stage of labour (low- to moderate-grade evidence)[5, 15]

- Selectively using episiotomy (low- to moderate-grade evidence).[5, 6, 9, 11, 12, 15, 33] Box 3 describes the indications for episiotomy
- Massaging the perineum before crowning (low- to moderate-grade evidence) [5, 29]
- Encouraging upright or lateral birth positions (low-grade evidence).[5, 34]

Box 3: Indications for consideration of episiotomy

Mediolateral episiotomy should be considered in instrumental vaginal birth, particularly for primaparous women.[6, 11, 16, 35]

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) notes episiotomy should also be considered in the following circumstances:

- A high likelihood of a third or fourth degree perineal tear
- Shoulder dystocia
- A need for accelerated delivery of a compromised fetus
- A history of female genital mutilation.[36]

Where episiotomy is considered appropriate, evidence indicates the use of a mediolateral technique performed by an appropriately trained and experienced clinician, with an insertion angle >60 degrees for a post-suture angle >40 degrees.[5, 6, 9, 11, 15, 37, 38]

Clinicians should follow their organisational protocols regarding the provision of evidence-based care. Outcome data should be collected and reviewed regularly at clinical review meetings, for example using the WHA CEC Perineal Protection Bundle[8] approach.

For health service organisations

Ensure that policies, procedures and protocols stipulate which evidence-based guideline(s) are to be used to reduce the risk of severe perineal tears and inform relevant clinicians of these requirements. Ensure relevant clinicians are appropriately trained and skilled to provide this care.[25]

Ensure that systems are in place to monitor variation in practice against expected health outcomes, as per Action 1.28 in the National Safety and Quality in Health Service (NSQHS) Standards (2nd ed). Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice. Use these data to inform improvements in safety and quality systems and record risks identified from unwarranted clinical variation in the risk management system.[17]

Quality statement 3 – Instrumental vaginal birth

When intervention is necessary for the safe birth of the baby, the choice of instrument is based on clinical need and consideration of the benefits and risks for each option, including the risk of a severe perineal tear.

Purpose

To ensure the decision about the choice of instrument considers the individual woman's clinical circumstances and the benefits and risks of each option, including the risk of a severe perineal tear and the potential benefit of episiotomy.

What the quality statement means

For women

Sometimes during labour, if your clinician is concerned about your health or the health of your baby, they may suggest active assistance to help the baby come out. The options might be:

- An instrumental vaginal birth (where the clinician uses either forceps or vacuum (ventouse) to help pull the baby out)
- A caesarean section (where the baby is born via a cut through the abdomen and uterus).

Your clinician will discuss these options with you. The decision about the best option will be based on your medical needs and the likely benefits and risks to you and the baby, in discussion with you.

Most instrumental deliveries occur without complications, but there is a small risk for you or your baby with each of the different options. If an instrument is used, the chance of having a severe perineal tear is lower with vacuum than with forceps. If forceps or vacuum are used, you may be offered an episiotomy to lower the risk of a severe perineal tear. Your clinician will also consider the safety of the baby. In some cases, an unplanned caesarean may be the safest option.

You will be asked to provide consent for this type of operative care, except in the case of emergency.

For clinicians

When intervention is indicated in a vaginal birth, the choice of intervention should be based on clinical need and the benefits and risks of the options.[12, 14, 16] Current RANZCOG[14] and RCOG[16] guidance include recommendations regarding the conditions for a safe instrumental vaginal birth and the need for a back-up plan in case of failure to deliver (see Box 4). Clinicians should be aware of the evidence regarding the risk profiles for forceps and ventouse, as described in current guidelines (see Table 1).

Instrumental vaginal birth may be indicated when there is:

- Foetal compromise
- A need to reduce the effects of the second stage of labour due to a medical condition
- Inadequate progress of the second stage of labour associated with risks to the foetus or mother.[14, 16]

Box 4 – RANZCOG recommendation: Conditions required for safe instrumental vaginal birth

Safe instrumental vaginal birth requires a careful assessment of the clinical situation, clear communication with the mother, and should be performed by, or in the presence of, an operator with expertise in the chosen procedure and the management of any complications which may arise.

For further detail see Royal Australian and New Zealand College of Obstetricians and Gynaecologists. C-Obs-16. Instrumental vaginal birth. Melbourne: 2016.

While forceps are less likely to result in a failed delivery, their use is associated with an increased risk of third and fourth degree perineal tears and other maternal adverse outcomes compared to vacuum-assisted delivery. Both forceps and vacuum-assisted delivery carry a small risk of any neonatal injury, but the nature of injuries differs between instruments[6, 15,39] (see Table 1). There are also limitations on the use of vacuum-assisted delivery associated with gestational age.[14, 16]

Table 1: Summary of risk associated with forceps and vacuum-assisted delivery*

Forceps compared to vacuum	Risk estimate
More likely to cause	
- third or fourth degree tears	RR 1.89, 95% CI 1.51-2.37
- any type of vaginal trauma	RR 2.48, 95% CI 1.59-3.87
- incontinence/altered continence	RR 1.77, 95% 1.19-2.62
Less likely to	
- fail to achieve a vaginal birth	RR 0.65 (95% CI 0.45-0.94)
Trend towards fewer cases of	
- cephalhaematoma	RR 0.64 (95% CI 0.37-1.11)
- fetal retinal haemorrhage	RR 0.6 (95% CI 0.43-1.06)
- neonatal jaundice	RR 0.79 (95% CI 0.59-1.06)
- shoulder dystocia	RR 0.4 (95% CI 0.16-1.04)
No significant difference between instruments	
- any neonatal injury	
- low Apgar score (<7) at 5 minutes	
- low pH (<7.2) in umbilical artery at birth	

* This table is based on the RANZCOG guideline for instrumental vaginal birth[14], which includes data from a Cochrane review of choice of instruments for assisted vaginal delivery.[39]

The risk of a severe perineal tear may be further reduced for both forceps and vacuum extraction with the use of mediolateral episiotomy (insertion angle >60 degrees) - consider offering to women, particularly those having their first vaginal birth (see Box 3). [5, 6, 11, 35, 38] Early discussion about this in the antenatal period may help prepare the woman should she face this situation. [16,40]

A back-up plan should be in place in the event of failure to achieve vaginal birth with the initial approach, taking into account the risks of each option (for example sequential use of instruments or caesarean section at full dilatation).[14, 16]

Discuss the options, including the likely benefits and risks of each option, with women and ensure that consent is documented in the healthcare record.[14]

For health service organisations

Ensure that policies, procedures and protocols stipulate the evidence-based guideline(s) that are to be used for instrumental vaginal birth and inform relevant clinicians of these requirements.[25]

Ensure that conditions for a safe instrumental birth are met within the facility, particularly with regard to senior staff, facilities and back-up plans in case of failure to deliver with an instrumental birth.[14, 16]

Ensure that clinicians are appropriately trained and experienced to provide safe, high-quality care during an instrumental vaginal birth, as per expected professional standards and their scope of clinical practice.[12]

Ensure that systems are in place to monitor variation in practice against expected health outcomes, as per Action 1.28 in the NSQHS Standards (2nd ed.). Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice. Use these data to inform improvements in safety and quality systems and record risks identified from unwarranted clinical variation in the risk management system.[17]

Quality statement 4 – Identifying third and fourth degree perineal tears

After a vaginal birth, and with her consent, a woman is examined by an appropriately trained clinician to exclude the possibility of a third or fourth degree perineal tear. Tears are classified using the Royal College of Obstetricians and Gynaecologists classification and are documented in the healthcare record.

Purpose

To ensure that women are assessed by a clinician who is trained to accurately identify severe perineal tears in a respectful way. Clinicians classify and report severe perineal tears using the Royal College of Obstetricians and Gynaecologists (RCOG) classification.

What the quality statement means

For women

After a vaginal birth, it is important that a clinician checks you to make sure you do not have a severe perineal tear. If a clinician does not repair a severe perineal tear quickly, the tear can cause serious problems in the long term.

To check for a severe perineal tear, the clinician will ask to check the area in and around the vagina and anus (back passage). The examination will be done with your consent and in a respectful manner. You have the right to ask the clinician to stop at any time.

Some injuries occur without an obvious tear or are difficult to see because of the swelling in the area.[41] These types of injuries can be hard to accurately identify and assess. So a second clinician may check that nothing has been missed to ensure you receive treatment that is appropriate for the type of injury you might have.

Severe perineal tears need to be repaired during an operation. If you have a severe perineal tear, you may need to be transferred so the repair can be undertaken. An obstetrician, or in some cases a colorectal surgeon, will usually carry out the repair.

For clinicians

All women who deliver their baby vaginally should be assessed for severe perineal tears immediately following birth.

This is a sensitive examination and should be conducted with respect and care.[9, 42] You should explain what the assessment will involve, get the woman's consent and offer appropriate pain management before assessment.[9] If a tear is identified, further systematic assessment should be conducted including a rectal examination to assess whether the internal or external anal sphincters have been damaged.[6, 9, 15, 41]

Use the RCOG classification[6] described in Box 5 to grade the severity of the injury. Ensure that a second, experienced clinician is available during examination to confirm the classification of the tear.[9, 11] If in doubt about the degree of the injury, classify it as more severe.[6] Incorrect classification can result in a suboptimal primary repair and increase maternal morbidity in the longer term.[41]

Record the outcome of the assessment in the woman's healthcare record and arrange transfer to a suitable environment, and refer her to an obstetrician or colorectal surgeon for treatment, if required.[9]

Box 5: Classification of perineal tears[6]

The Royal College of Obstetricians and Gynaecologists (RCOG) classifies perineal tears as follows:

- First degree tear: injury to perineal skin and/or vaginal mucosa
- Second degree tear: injury to perineum involving perineal muscles but not involving the anal sphincter
- Third degree tear: injury to perineum involving the anal sphincter complex
  - Grade 3a tear – less than 50% of external anal sphincter (EAS) thickness torn
  - Grade 3b tear – more than 50% of EAS thickness torn
  - Grade 3c tear – both EAS and internal anal sphincter (IAS) torn
- Fourth degree tear: injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

Note: Rectal buttonhole injuries involve a tear of the rectal mucosa with an intact anal sphincter complex and, visually, there is no obvious damage to the perineum.[6] If not recognised and repaired, this type of tear may lead to a rectovaginal fistula. These types of injuries should be repaired.

Rectal buttonhole tears are not included in the RCOG classification and should be documented separately.

For health service organisations

Ensure that policies, procedures or protocols for identification of severe perineal tears are consistent with current evidence-based guidelines[26], including a reference to the RCOG classification system.

Ensure policies support clinicians to routinely offer an examination to assess women for perineal injuries, including a rectal examination, and ensure that a second, experienced clinician is available during examination to exclude the possibility of a severe perineal tear.

Ensure that the workforce is appropriately trained in perineal anatomy and the use of the RCOG classification[6] to ensure clinical competence in the assessment, classification and reporting of severe perineal tears and respectful communication with women. Accurate classification of the injury is important, as it will further guide appropriate management of severe perineal tears by an appropriately skilled workforce.[5, 41]

Ensure that systems are in place to monitor variation in practice against expected health outcomes as per Action 1.28 in the NSQHS Standards (2nd ed.). Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice. Use these data to inform improvements in safety and quality systems and record risks identified from unwarranted clinical variation in the risk management system.[17]

Quality statement 5 – Repairing third and fourth degree perineal tears

When a third or fourth degree perineal tear occurs, it is promptly repaired by an appropriately trained and experienced clinician in a suitable environment.

Purpose

To ensure severe perineal tears are repaired promptly by appropriately trained clinicians according to current best practice or evidence-based guidelines, and – where possible – in an operating theatre where there is access to appropriate equipment and clinical support.

What the quality statement means

For women

If you have a severe perineal tear, your clinician will talk to you about how your injury should be repaired. Severe perineal tears are usually repaired in a hospital or an operating theatre, to make sure you are safe and comfortable. A clinician who is trained to do this type of surgery will fix the tear. The clinician will try to make sure your baby and support person remain with you during the surgery.

Perineal tears are repaired with dissolving stitches that do not need to be removed. You will need a local or general anaesthetic. You may also get a dose of antibiotics to prevent wound infection.

For clinicians

Accurate identification and prompt repair of severe perineal tears is important to minimise the risk of infection, blood loss, pain and incontinence, as well as long-term physical, emotional and sexual health consequences for women.[9, 41]

Talk to the woman about the nature of her injury and the procedure for repair. Provide reassurance regarding her recovery and the expected outcome of the repair. Clinicians who respond in a respectful and dignified manner can improve the woman's experience of care.[42]

Only appropriately trained and experienced clinicians[6, 9, 15, 43] should repair third or fourth degree perineal tears, as per their clinical scope of practice.[14] If you are not trained or credentialed to repair a third or fourth degree perineal tear, refer women to an appropriately qualified clinician.[9] Registrars should be supervised by a senior clinician[6], unless they have completed their Assessment of Procedural and Surgical Skills or the equivalent level of credentialing or training for the repair of third or fourth degree perineal tears.

Clinicians should conduct the surgical repair as soon as possible to minimise the risk of infection and blood loss.[9] The repair should be undertaken in a suitable environment, such as an operating theatre with good lighting and access to appropriate equipment.[15,6, 9, 42] In some circumstances – for example, an uncomplicated procedure to repair a 3a tear that is not bleeding – the repair may be done in a birthing suite. However, only a senior consultant or credentialed general practitioner obstetrician should make this decision.[6] The requirement for a clean environment, and access to trained clinicians and suitable equipment remain the same.

The repair should be conducted under local or general anaesthesia[6], using techniques and materials that are consistent with an evidence-based guideline. A rectal examination should be performed after repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa.[9]

Some women may decline surgical treatment because they do not want to be separated from their baby. Advise the woman that it may be possible for her baby and support person to be present during repair.[9]

The evidence for prophylactic antibiotics for severe perineal tears is limited.[5,44] However, given the high risk of faecal contamination and infection, which may worsen the consequences of a severe perineal tear, giving prophylactic antibiotics is recommended [6, 12, 13, 15, 45,] or considered reasonable[11, 43] for severe perineal tears.

Clinicians decide about using antibiotics prophylactically on a case-by-case basis. When antibiotics are prescribed, clinicians should follow recommendations in the current *Therapeutic Guidelines: Antibiotic,*[46,47]

Document the injury and repair method in the woman's healthcare record.[6, 9, 12]

For health service organisations

Ensure that policies, procedures and protocols for the repair of severe perineal tears are consistent with current best practice or evidence-based guidelines. [26] Policies should include a provision to enable the woman's baby and support person to be present in the operating theatre during repair, noting that some women may decline surgical treatment because they do not want to be separated from their baby.[9]

Ensure that clinicians are appropriately trained and skilled. Ensure that operating theatres are accessible to enable timely repair of severe perineal tears.[26] Ensure that women are transferred to an appropriate facility, if required.

Ensure that systems are in place to monitor variation in practice against expected health outcomes, as per Action 1.28 in the NSQHS Standards (2nd ed.). Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice. Use these data to inform improvements in safety and quality systems and record risks identified from unwarranted clinical variation in the risk management system.[17]

Quality statement 6 – Postoperative care

After repair of a severe perineal tear, a woman receives postoperative care that includes debriefing, physiotherapy and psychosocial support before discharge.

Purpose

To ensure that women receive postoperative care that optimises their recovery from a severe perineal tear immediately after surgery.

What the quality statement means

For women

Right after surgery, you might need medicines to manage pain or constipation, or to prevent infection. You may also have a urinary catheter for a short period of time to help you urinate.

While in hospital, your clinician will discuss your experience. This will give you a chance to ask questions about how your injury was repaired. Your clinician will also let you know what you need to do to look after your injury in the short and long term.

Before leaving hospital, you should see a physiotherapist who can let you know what to do or what to avoid while recovering. The physiotherapist will also work with you and your midwife to work out the best positions for breast feeding, if you choose to do so. You may feel unsettled after this type of injury, so you may also meet with a psychologist or social worker who can provide more advice and support you at home.

Before going home, you should receive written information about your injury, including information about what to expect and how to care for your injury. Your general practitioner will be sent a copy of your hospital discharge summary describing the care you received and any referrals or follow-up needed. Ask if any follow-up appointments have been made for you.

For clinicians

Ensure that pain relief, postoperative antibiotic therapy and laxatives are prescribed and administered as appropriate[9, 11], and advise women of any implications for breastfeeding. Monitor the woman's bladder and bowel function before discharge.[11, 12]

While in hospital, give the woman an opportunity to discuss her recent experience and to ask questions.[9] Arrange an appointment with a physiotherapist and counsellor or psychologist before she leaves hospital. Provide information about the nature of the injury, how to care for the injury at home and what to expect while recovering in the short and long term.[6, 9]

Ensure the woman's discharge summary includes information about referrals and follow-up care required and that her general practitioner receives a copy.[48] Schedule relevant appointments when possible – for example, at a clinical that specialises in managing severe perineal tears.

For health service organisations

Ensure that policies, procedures and protocols for postoperative care of women who experience a severe perineal tear are in line with evidence-based guidelines.

Policies should note the expected length of stay women for women with a severe perineal tear will be longer than the average length of stay for maternity services. These women will need increased access to services such as physiotherapy, psychological and domiciliary support before leaving hospital.

Ensure that relevant clinicians are trained to communicate with affected women to discuss the implications and management of a severe perineal tear, and to provide a supportive environment. Ensure that resources are available for clinicians to give to women to support their recovery from surgery and that mechanisms are in place for appropriate referral and follow-up.

Quality statement 7 – Follow-up care

A woman with a severe perineal tear receives individualised follow-up care and appropriate referral to optimise her ongoing physical, emotional, psychological and sexual health.

Purpose

To ensure that all women who experience a severe perineal tear receive appropriate follow-up care to optimise their physical, emotional, psychological and sexual health, and that appropriate referral pathways are in place.

What the quality statement means

For women

After leaving hospital, you should receive follow-up care to make sure you have the best possible physical and emotional recovery and to provide advice for future pregnancies. Your general practitioner and a physiotherapist with expertise in women's health will have a key role in looking after you and will help you get the care you need.

You can expect a follow-up appointment with an experienced clinician, who is familiar with your history in the weeks after your baby is born. They will check that your injury is healing and discuss any other problems you may experience. They can also help you if you have concerns about pain, incontinence, sexual activities, exercise or relationship difficulties as a result of your injury. You may feel sad or tearful for a period of time after this type of injury.

To best support your recovery, you may be offered a number of specialist services, such as:

- Clinics that specialise in treating women with severe perineal tears
- Physiotherapists with experience in pelvic floor training
- Continence nurses
- Psychologists, sexual health therapists or relationship counsellors
- Other specialist doctors like obstetricians or colorectal surgeons.

It is important to talk to your support person as they may also need help to understand what has happened and how to support you while you recover. They may also need support or counselling so they can look after their own health and wellbeing. You may choose for both of you to go to your appointments.

For clinicians

Women who experience a severe perineal tear will need individualised follow-up care.

Ensure the woman has a follow-up appointment with a clinician who has relevant expertise and is familiar with her case history, in the weeks after discharge, to assess the woman's physical, emotional and psychological recovery.[11]

Refer the woman to a multidisciplinary perineal clinic or other service providers, such as a physiotherapist with experience in pelvic floor training, psychologist or sexual health clinic, to meet her needs and preferences. A specialist referral may also be required for ongoing care of any physical, emotional or psychological consequences that arose as a result of the woman's severe perineal tear. This may also be a good time to discuss any issues that may affect future births.[6, 11, 14, 15]

Acknowledge that, if a support person was present during labour and birth, and witnessed a traumatic birth, it may affect their health and wellbeing. Offer them an opportunity to debrief as well as referring them for support or counselling if required.

If you are the woman's general practitioner you will have a role in checking the woman's health after discharge and referring her for follow-up treatment, as recommended. You may also identify new problems that result from the woman's injury, such as perinatal anxiety and depression, incontinence or relationship difficulties. You may need to refer her and/or her support person for extra support and services.[48]

For health service organisations

Ensure that policies, procedures or protocols describe the care that is expected to optimise a woman's physical and psychological recovery from a severe perineal tear. Ensure that systems are in place to enable referrals.[26]

Where possible, ensure that support or referral pathways for a multidisciplinary team-based approach or a clinic that specialises in treating women with severe perineal tears are available. This should ensure access to the full range of services that women are likely to need – for example, obstetricians, colorectal surgeons, physiotherapists, psychological support services and continence nurses.

Appendix A: Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and local health service organisations in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

The process to develop the indicators specified in this document comprised:

- A review of existing local and international indicators
- Prioritisation, review and refinement of the indicators with the Severe (third and fourth degree) Perineal Tears Working Group.

Most of the data underlying these indicators are collected from local sources, mainly through prospective data collection or a retrospective chart review. Where an indicator refers to 'local arrangements', these can include clinical guidelines, policies, protocols, care pathways or any other documentation providing guidance to clinicians.

Monitoring the implementation of the clinical care standard will help organisations to meet some of the requirements of the NSQHS Standards. Information about the NSQHS Standards is available at the NSQHS Standards website.

Full specifications of the Severe (third and fourth degree) Perineal Tears Clinical Care Standard indicators will be published in the Metadata Online Registry (METeOR).

METeOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METeOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

Clinical indicators

Instrumental delivery rate for first birth

1) Proportion of women who had an instrumental vaginal birth for their first birth

Numerator - number of women who had an instrumental vaginal birth for their first birth

Denominator - number of women who gave birth vaginally for their first birth

Vacuum-assisted and forceps-assisted delivery rate for first birth*

2) Proportion of women who had an instrumental vaginal birth using vacuum for their first birth

Numerator - number of women who had an instrumental vaginal birth using vacuum for their first birth

Denominator - number of women who gave birth vaginally for their first birth

3) Proportion of women who had an instrumental vaginal birth using forceps for their first birth

Numerator - number of woman who had an instrumental vaginal birth using forceps for their first birth

Denominator - number of women who gave birth vaginally for their first birth

***Computation notes**

Women who had an instrumental vaginal birth using both vacuum and forceps should be capture in indicator 3 only (instrumental vaginal birth using forceps)

Instrumental delivery with episiotomy for first birth

4) Proportion of women who had a vacuum-assisted birth with episiotomy for their first birth

Numerator - number of women who had an instrumental vaginal birth using vacuum and had an episiotomy performed

Denominator - number of women who had an instrumental vaginal birth using vacuum for their first birth

5) Proportion of women who had a forceps-assisted birth with episiotomy for their first birth

Numerator - number of women who had an instrumental vaginal birth with forceps and had an episiotomy performed

Denominator - number of women who had an instrumental vaginal birth with forceps for their first birth

Dual instrumental delivery rate for first birth

6) Proportion of women who had an instrumental vaginal birth using both vacuum and forceps for their first birth

Numerator - number of women who had an instrumental vaginal birth with forceps and vacuum

Denominator – number of women who had an instrumental vaginal birth for their first birth

Hospital-acquired complications – third and fourth degree perineal laceration during delivery

7) Proportion of women who gave birth and acquired a third degree perineal laceration

Numerator – number of women who gave birth and acquired a third degree perineal laceration

Denominator – number of women who gave birth vaginally

8) Proportion of women who gave birth and acquired a fourth degree perineal laceration

Numerator – number of women who gave birth and acquired a fourth degree perineal laceration

Denominator – number of women who gave birth vaginally

Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of health care is an important way to ensure that the patient's perspective drives service improvements and person-centred care. This is the case in all health services.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete, without any input from health professionals. They are often administered at least twice to an individual patient – at baseline and again after an intervention or at regular intervals during a chronic illness. The information contributed by patients filling out PROMs questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Patient experience measures

This clinical care standard does not include indicators specific to measuring patient experiences. The Commission strongly encourages organisations to adopt the Australian Hospital Patient Experience Question Set (AHPEQS). AHPEQS is a 12-question generic patient experience survey that has been found to be reliable and valid for both day-only and admitted hospital patients across many clinical settings. The instrument is available for download to both private and public sector health services

Appendix B: Integration with the National Safety and Quality Health Service Standards

The Commission developed the NSQHS Standards in collaboration with the Australian Government, states and territories, clinical experts, and consumers. The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

The second edition of the NSQHS Standards was launched in November 2017, and health service organisations have been assessed against the new standards since January 2019.

In the NSQHS Standards (2nd ed.), the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all health service organisations.

The Clinical Governance Standard aims to ensure that systems are in place within health service organisations to maintain and improve the reliability, safety and quality of health care.

The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care, to the extent that they choose.

Under the NSQHS Standards (2nd ed.), health service organisations are expected to support clinicians to use the best-available evidence, including clinical care standards such as the Severe Perineal Tears Clinical Care Standard (see Action1.27b of the NSQHS Standards).

Health service organisations are expected to implement the NSQHS Standards in a way that suits the clinical services provided and their associated risks. Other aspects of the NSQHS Standards (2nd ed.) that are relevant to this clinical care standard are included in Table 2.

Table 2: Aspects of the NSQHS Standards relevant to this clinical care standard

Clinical Governance Standard	Partnering with Consumers Standard	Medication Safety Standard	Comprehensive Care Standard	Communicating for Safety Standard
Governance, Leadership and culture (1.1 and 1.2)	Healthcare rights and informed consent (2.3, 2.4 and 2.5)	Medication reconciliation (4.6)	Integrating clinical governance (5.1)	Clinical handover (6.7)
Clinical leadership (1.6)	Sharing decisions and planning care (2.6 and 2.7)		Applying quality improvement systems (5.2)	Communicating critical information (6.9)
Policies and procedures (1.7)	Communication that supports effective partnerships (2.8, 2.9 and 2.10)		Partnering with consumers (5.3)	Documentation of information (6.11)
Measurement and quality improvement (1.8 and 1.9)			Designing systems to deliver comprehensive care (5.4)	
Safety and quality training (1.19 and 1.20)			Collaboration and team work (5.5 and 5.6)	
Performance management (1.22)			Planning for comprehensive care (5.7)	
Credentialing and scope of clinical practice (1.23 and 1.24)			Screening of risk (5.10)	
Evidence-based care (1.27)			Clinical assessment (5.11)	
Variation in clinical practice and health outcomes (1.28)			Developing the comprehensive care plan (5.12 and 5.13)	
Safe environment for the delivery of care (1.29)			Delivering comprehensive care (5.14)	

Glossary

antenatal	The period between conception and the onset of established labour.[49]
assessment	A clinician's evaluation of a disease or condition, based on[50]: • The patient's report of the symptoms and course of the illness or condition • Information reported by family members, carers and other members of the healthcare team • The clinician's objective findings (including data obtained through tests, physical examination and medical history, and information reported by family members and other members of the healthcare team).
best-available evidence	The best systematic research evidence available that is used to support decisions about the care of individual patients.
best practice guidelines	A set of recommended actions that are developed using the best-available evidence. They provide clinicians with evidence informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[17]
buttonhole tear	See 'Rectal buttonhole tear'.
caesarean section	An operation in which a baby is born through an incision (cut) made through the mother's abdomen and the uterus (womb).[51]
clinician	Maternity clinicians may include: • General practitioners • Midwives, obstetricians and gynaecologists • Aboriginal and Torres Strait Islander health practitioners • Anaesthetists • Colorectal surgeons • Physiotherapists. See also 'Clinician'.
clinical care standards	Nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.
clinical practice guidelines	Systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.[17]
clinician	A healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision. [17]

	See also ‘Maternal clinician’.
competence	The possession of required skills, knowledge, education and capacity.[21]
consultation	The seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It depends on the existence of collaborative relationships, and open communication, with others in the multidisciplinary team.[21]
credentialing	The formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician’s competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[17]
dystocia	Difficult labour or abnormally slow progress of labour. Other terms that are often used interchangeably with dystocia are dysfunctional labour, failure to progress (lack of progressive cervical dilatation or lack of descent) and cephalopelvic disproportion.[52]
episiotomy	A cut made by a clinician through the vaginal wall and perineum to make more space to deliver the baby.[4] A midline or median episiotomy starts within 3 mm of the midline in the posterior fourchette and extends downwards between 0 degrees and 25 degrees of the sagittal plane.[11] A mediolateral episiotomy starts within 3 mm of the midline in the posterior fourchette and is directed laterally at an angle of a least 60 degrees from the midline towards the ischial tuberosity.[11] See also ‘routine episiotomy’ and ‘selective episiotomy’.
evidence-based practice	Accessing and making judgements to translate the best-available evidence into practice. Evidence-based practice is based on the most current, valid, and available research, and considers the midwife’s clinical experience and the woman’s expectations.[21]
healthcare record	Includes a record of the patient’s medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.[17]
health literacy	The Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[17]
health service organisation	A separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care

	at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[17]
informed consent	A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or take part in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[17] See also 'Shared decision making'.
instrumental vaginal birth	A delivery in which the operator uses forceps, a vacuum or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing. The decision to use an instrument to deliver the fetus balances the maternal, fetal and neonatal impact of the procedure against the alternative options of caesarean birth or expectant management.[53]
maternity care	Care provided during pregnancy and in the 12 months after giving birth. [49]
multidisciplinary team	A team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. (A discipline is a branch of knowledge within the health system.)[17]
obstetric anal sphincter injuries (oasis)	See 'Severe perineal tear' and 'rectal buttonhole tear'.
operative vaginal birth	See 'Instrumental vaginal birth'.
partnership	When patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.[17]
perinatal period	The period covering pregnancy and the first year after pregnancy or birth.[54]

perineal tear	A tear of the skin and other tissues between the vagina and anus. The following classification is commonly used to describe the degree of the injury[6]:
	
	• First degree tear: injury to perineal skin and/or vaginal mucosa
	• Second degree tear: injury to perineum involving perineal muscles but not involving the anal sphincter
	• Third degree tear: injury to perineum involving the anal sphincter complex
	  ○ Grade 3a tear – less than 50% of external anal sphincter (EAS) thickness torn
	  ○ Grade 3b tear – more than 50% of EAS thickness torn
	  ○ Grade 3c tear – both EAS and internal anal sphincter (IAS) torn
	• Fourth degree tear: injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.
	Perineal tears may also be referred to as perineal lacerations.
	
	See also 'Severe perineal tear'.

person-centred care	An approach to the planning, delivery and evaluation of health care that is founded on mutually helpful partnerships among clinicians and consumers. Person-centred care is respectful of, and responsive to, the preferences, needs and values of consumers. Key dimensions of person-centred care include: • Respect • Emotional support • Physical comfort • Information and communication • Continuity and transition • Care coordination • Involvement of carers and family • Access to care. Also known as patient-centred care or consumer-centred care.[17] See also 'Woman-centred care'.
postnatal care	Care of the woman in the 12 months after giving birth.[49]
psychosocial	Social factors that have the potential to affect a woman's emotional wellbeing.[54]
quality improvement	The combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. Quality improvement activities may be undertaken in sequence, intermittently or continually.[17] Numerous models can be used; all share the same focus to reduce errors, and unnecessary morbidity and mortality.
rectal buttonhole tear	A tear that involves the rectal mucosa with an intact anal sphincter complex. This type of tear must be documented as a rectal buttonhole tear. It is **not** a fourth degree tear. If not recognised and repaired, a rectal buttonhole tear may lead to a rectovaginal fistula.[6]

risk factor	Any variable (for example, smoking, abnormal blood lipids, elevated blood pressure, diabetes) that is associated with a greater risk of a health disorder or other unwanted condition or event.
routine episiotomy	A surgical cut of the vagina and perineum performed on all women undergoing vaginal birth.[5] See also 'episiotomy'.
scope of practice	The extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[17]
selective episiotomy	A surgical cut of the vagina and perineum performed as required on women undergoing vaginal birth.
severe perineal tear	A third or fourth degree perineal tear. A third degree perineal tear involves injury to the perineum involving the anal sphincter (muscle controlling the anus). A fourth degree perineal tear involves the anal sphincter and the anal mucosa (the lining of the anus or rectum).[6] See also 'Perineal tear'.
shared decision making	A consultation process in which a clinician and a patient jointly take part in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[17]
shoulder dystocia	When the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. If this happens, extra help is usually needed to release the baby's shoulder.[55]
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: • Brings together risk management, governance, and operational processes and procedures, including education, training and orientation • Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials • Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures. The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.[17]
timely (communication)	Communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.[17]
training	The development of knowledge and skills.[17]

transitions of care	Situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's condition and care needs change.[17]
vaginal birth	Non-instrument-assisted births.
woman-centred care	Care that recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices. Woman-centred care is the focus of midwifery practice in all settings.[21] See also 'Person-centred care'.

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